AUTHORIZED REPRESENTATIVE (AR) DECLARATION

You may choose an Authorized Representative (AR) to help you apply for or get benefits. You must fill out this form for every AR you choose.

An AR is a friend, family member, other adult, or an agency that has a concern for your wellbeing. You must choose your own AR. Your AR must agree to help you.

DHHS will talk to your AR until you or your AR tells us otherwise.

AUTHORIZED REPRESENTATIVE DUTIES

Please check off the things that you want your AR to do for you:

☐ Get, fill out, and sign applications, forms, and other DHHS paperwork for me.

☐ Get a copy of all my notices from DHHS.

☐ Go to my eligibility interviews for me.

☐ Get an EBT card with my AR's name on it. (I will still get my own EBT Card. My AR and I will both be able to call EBT Customer Service.) My AR's EBT card will access my ☐ Food Stamps and/or ☐ Cash.

OR

☐ Talk to EBT Customer Service for me. (I will be the only one to get an EBT Card.)

☐ Request and represent me at an Administrative Appeal.

☐ Talk to my managed care organization (MCO) or qualified health plan (QHP) for me.

☐ Other: _____

CLIENT'S SIGNATURE

Please read the following statements carefully. Your signature below means you have read, understand, and agree to these statements.

- **I certify** that I have read and understand the information on this form.
- **I authorize** my AR to perform the duties checked on this form until I or my AR tells DHHS of a change.
- **I understand** that I am responsible for any errors, omissions, or inaccurate information that my AR reports to DHHS.
- **I understand** that if my AR uses my benefits without my permission, these benefits will not be replaced by DHHS.
- **I understand** that if I am living at a drug and alcohol treatment center or am part of another group living arrangement and my AR is that agency, in accordance with 7 CFR 273.11(f)(5)(ii), that agency will automatically no longer be my AR once I leave.

_____ _____
Client's **Printed** Name Date

_____ _____
Client's Signature Date of Birth

_____ _____
MID # Case #

(Please Turn Over)

AUTHORIZED REPRESENTATIVE INFORMATION

Please tell us your AR's name, address, and telephone number. If your AR is an Agency, please tell us the name of a contact person in that agency. Please print clearly.

First Name | Middle Initial | Last Name

Street/Mailing Address | Telephone Number

City, State, and Zip Code | Alternate Telephone Number

Date of Birth (Must be 18 or older) | Describe your relationship to your AR (If your AR is an agency, write the name of the agency here.)

AUTHORIZED REPRESENTATIVE'S SIGNATURE

My signature below means that I have read and understand the information on this form. I agree to accept the duties noted on this form and understand and agree to the following:

- **I agree** to represent the client, as described on this form, until I or the client tells DHHS of a change.
- **I agree** to give proof of my identity to act as an AR.
- **I certify** that I am concerned for the client's wellbeing.
- **I certify** that I am knowledgeable about the client's circumstances or can get more information.
- **I certify** that if I am signing for an agency, I have the authority to do so.
- **I agree** to protect confidential information in accordance with state and federal law.
- For clients applying for or receiving Medicaid if I am acting for an agency **the agency agrees** to:
  - Safeguard information about the client; (42 CFR 431.300 et. seq.) and
  - Keep the client's tax information confidential; (45 CFR 155.260(f))
- If I am acting on behalf of a Medicaid provider **the provider agrees** not to reassign Medicaid claims except as allowed by 42 CFR 447.10.
- **I understand** that if I have been disqualified for a program violation, I cannot act as an AR unless there is no one else suitable to represent this individual.
- **I understand** that if I am an AR for a Food Stamp recipient in a drug and alcohol treatment center or other group living arrangement, and I give erroneous information which leads to the resident I represent getting too many benefits, those benefits will be recouped from the treatment center or group living arrangement group, not just the resident I represent, and the center will be reported to USDA SNAP licensing per 7 CFR 273.11(e)(7).

Authorized Representative's **Printed** Name | Date

Authorized Representative's Signature

Return to: Centralized Scanning Unit (CSU), P.O. Box 181, Concord, NH 03301